

# UNIFORM SUSPECTED INSURANCE FRAUD REPORTING FORM

State of Iowa  
Division of Insurance – Fraud Bureau

**For State Use Only**

Case No.

## Reporting Person Information

Name and Title:	Insurance Company:	NAIC#
Mailing address (include department):		Phone number: (    )
		Fax number: (    )
		E-mail address:

## Case Details

SIU Investigation Completed:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date Completed:	SIU Case #:
Civil Litigation Pending:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Is there any reason to believe that this incident is related to other suspected fraudulent activity? <input type="checkbox"/> Yes <input type="checkbox"/> No			

## Subject Information

Type:	Name (Last / Business):	(First):	(Middle):	Date of birth:	Age:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Street Address (include P.O. Box and apartment #'s):			Driver's License # & State:	SSN: NPI:	TIN: EIN:	
City:	State:	Zip:	County:	Telephone No.: (    )	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.	
Address Type: <input type="checkbox"/> Res. <input type="checkbox"/> Bus. <input type="checkbox"/> Maildrop <input type="checkbox"/> Other _____			E-Mail Address:	Telephone No.: (    )	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.	
VIN:		License Plate # & State:	Vehicle Yr:	Make:	Model:	
Employer:		Address & Phone #:			Occupation:	
Additional Subject/Party Involved? <input type="checkbox"/> AKA Information? <input type="checkbox"/> <b>If checked, complete Page 3</b>		Reported Injuries:	Comments: (ex. other ID information and source)			

## Claim/Incident Information

(all financial information and dates of service are considered approximate)

Claim #	Policy #:	Insurance Company Case #:	Insurance Type <input type="checkbox"/> Property/Casualty <input type="checkbox"/> Disability <input type="checkbox"/> Work Comp <input type="checkbox"/> Auto <input type="checkbox"/> Health <input type="checkbox"/> Life <input type="checkbox"/> Unknown <input type="checkbox"/> Other
Potential Loss Amount \$		Amount Paid \$ Date Paid	Reserve Amount \$
<input type="checkbox"/> Unknown. Please estimate: <input type="checkbox"/> \$1 - \$5,000 <input type="checkbox"/> \$5,001 - \$25,000 <input type="checkbox"/> \$25,001 - \$75,000 <input type="checkbox"/> \$75,001 + <input type="checkbox"/> Unable to estimate		Billed Amount \$	Dates of Service: _____ to _____
		Settlement Amount \$ Date Paid	Description of Service: _____
		Procedure Code Type: <input type="checkbox"/> CPT <input type="checkbox"/> CDT Procedure Codes: _____	
Date of Loss / Injury: Address:  City:                      County:                      State:                      Zip:		THIS SPACE IS INTENTIONALLY LEFT BLANK	

## Identify Another Agency You Have Contacted Regarding This Referral

Agency Type: <input type="checkbox"/> Other State Fraud Bureau <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Other Insurance Co. <input type="checkbox"/> Regulatory/Gov't Agency <input type="checkbox"/> Other	
Agency: _____	Contact Person: _____
(Address) _____	(City) _____ (State) _____ (Zip) _____
Telephone (    ) _____	Fax (    ) _____ E-mail _____ Case/Claim No. _____

**Evidence (check all that apply)**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Claim History Extracts          | <input type="checkbox"/> External Database results              | <input type="checkbox"/> Medical Records                          |
| <input type="checkbox"/> Claim Information               | <input type="checkbox"/> EUO / Deposition                       | <input type="checkbox"/> Proof of Loss                            |
| <input type="checkbox"/> Continuance of Disability Forms | <input type="checkbox"/> IME Reports                            | <input type="checkbox"/> Statements (Witness / Insured / Subject) |
| <input type="checkbox"/> Copies of Receipts              | <input type="checkbox"/> Investigative Reports                  | <input type="checkbox"/> Sworn <input type="checkbox"/> Recorded  |
| <input type="checkbox"/> Death Certificate               | <input type="checkbox"/> Internet/Social Media Search Results   | <input type="checkbox"/> Videos / Photos                          |
| <input type="checkbox"/> Expert Reports                  | <input type="checkbox"/> Law Enforcement / Other Agency Reports | <input type="checkbox"/> Other                                    |

**Suspected Fraud Types (check all that apply)****PROPERTY/CASUALTY**

- ☐ Arson
  - ☐ home ☐ vehicle ☐ business
- ☐ Fictitious loss ☐ damages ☐
- ☐ Fictitious theft
  - ☐ vehicle ☐ property
- ☐ Inflated inventory
- ☐ Inflated loss ☐ damages ☐
- ☐ Inflated theft
  - ☐ vehicle ☐ property
- ☐ Double-dipping
- ☐ Exaggerated injuries
- ☐ Injuries not related to work
- ☐ Malingerers
- ☐ Misappropriated vehicle salvage
- ☐ Premium avoidance
- ☐ Prior injuries/damage/loss
- ☐ Slip and fall
- ☐ Staged injury / accident at work
- ☐ Staged vehicle collision
- ☐ Paper accident
- ☐ Other \_\_\_\_\_

**GENERAL**

- ☐ Agent fraud
- ☐ Application/Eligibility fraud
- ☐ Billing for services/products not provided
- ☐ Failure to disclose multiple insurance companies
- ☐ False claims
- ☐ Illegal solicitation (cappers)
- ☐ Issued, possessed, or sold fraudulent insurance policies, certificates, binders, or ID cards
- ☐ Misrepresentation of services / products provided
- ☐ Kickbacks/bribery
- ☐ Money laundering
- ☐ Multiple claims
- ☐ Questioned documents
  - ☐ altered ☐ forged ☐ falsified
  - ☐ duplicated
- ☐ Received compensation for referral to health care provider or attorney
- ☐ Ring / organized activity

**HEALTH CARE**

- ☐ Changing dates of service, CPT/CDT/diagnostic codes
- ☐ Charges inconsistent with services, products, or supplies provided
- ☐ Duplicate billing for same service
- ☐ False/phantom provider
- ☐ Forged prescriptions
- ☐ Fraudulent death claims
- ☐ Misrepresented non-covered services as covered
- ☐ Over-utilization of services
- ☐ Prescription abuse / doctor shopping
- ☐ Prescriptions issued for non-medical purposes
- ☐ Unbundling
- ☐ Upcoding
- ☐ Using unqualified/unlicensed persons to perform billable services
- ☐ Other \_\_\_\_\_

**Detailed Synopsis**

Attach additional pages, if necessary.

**Subject / Additional Party Types****GENERAL TYPES**

- IS Adjuster
- IB Agent/Broker
- IR Appraiser
- BS Body Shop
- CL Claimant
- IY Insurance Company Employee
- IN Insured/Member
- INS Insurer
- LC Lawyer for Claimant
- LI Lawyer for Insured
- SY Salvage Yard Owner / Employee
- SI Self-Insured
- TY Tow Yard Owner / Employee
- WT Witness
- OT Other
- \_\_\_\_\_

**MEDICAL TYPES**

- AMB Ambulance Service/Employee
- BS Billing Service
- CHI Chiropractor
- DS Dental Specialist
- \_\_\_\_\_
- DEN Dentist
- DME DME Supplier
- DO Doctor of Osteopathic Medicine
- FC Facility
- FP False/Phantom Provider
- HHA Home Health Agency
- HS Hospital
- MR Laboratory
- LPN Licensed Practical Nurse
- MT Massage Therapist
- MH Medical Clinic/Outpatient Facility
- MD Medical Doctor
- MS Medical Specialist

- NP Nurse Practitioner
- NS Nurse Specialist
- MZ Office Administrator
- OPT Ophthalmologist
- OP Optometrist
- PH Pharmacist
- PT Physical Therapist
- PA Physician's Assistant
- PO Podiatrist
- PS Psychiatrist
- PY Psychologist
- RD Radiologist
- TH Therapist/Counselor
- TPA Third Party Administrator
- UP Unlicensed Provider
- MN Other Medical Personnel
- \_\_\_\_\_

Additional Subject /Interested Party or AKA Information									
<b>Type:</b>	Name (Last / Business):		(First):		(Middle):		Date of birth:	Age:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Street Address (include P.O. Box and apartment #'s):			Driver's License # & State:		SSN: NPI:		TIN: EIN:		
City:		State:	Zip:	County:		Telephone No.: ( )		Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.	
Address Type: <input type="checkbox"/> Res. <input type="checkbox"/> Bus. <input type="checkbox"/> Maildrop <input type="checkbox"/> Other _____			E-Mail Address:		Telephone No.: ( )		Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.		
VIN:			License Plate # & State:		Vehicle Yr:		Make:		Model:
Employer:			Address & Phone #:					Occupation:	
<b>Subject:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		Describe Involvement:							

Additional Subject /Interested Party or AKA Information									
<b>Type:</b>	Name (Last / Business):		(First):		(Middle):		Date of birth:	Age:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
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VIN:			License Plate # & State:		Vehicle Yr:		Make:		Model:
Employer:			Address & Phone #:					Occupation:	
<b>Subject:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		Describe Involvement:							

**SEND FORM TO: Iowa Insurance Fraud Bureau, 601 Locust, 4<sup>th</sup> Floor, Des Moines, IA 50309-3738, or FAX to 515-242-5303.**

**If you choose to send it via e-mail, please be advised that it will be transmitted unencrypted over the Internet. Encryption is not available at this time, so confidentiality in the transmission can not be guaranteed. If you have questions, call 515-242-5304.**

Iowa Code 507E.7 Immunity from liability.

1. A person acting without malice, fraudulent intent, or bad faith is not liable civilly as a result of filing a report or furnishing, orally or in writing, other information concerning alleged acts in violation of this chapter, if the report or information is provided to or received from any of the following:

- Law enforcement officials, their agents and employees.
- The national association of insurance commissioners, the insurance division, a federal or state governmental agency or bureau established to detect and prevent fraudulent insurance acts, or any other organization established for such purpose, and their agents, employees, or designees.
- An authorized representative of an insurer.

2. This section does not affect in any way any common law or statutory privilege or immunity applicable to such person or entity.

3. A person or entity against whom an action is brought for libel, slander, or any other relevant tort, where the action involves acts subject to immunity under this section and is not substantially justified, is entitled to an award of court costs and reasonable attorney fees. For purposes of this section, an action is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.